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March 15, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Secretary Azar and Administrator Verma:

We write today regarding Part I and Part II of the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2019 Advanced Notice and Call Letter released on December 27, 2017, and February 1, 2018, respectively. Part I and Part II of the Advanced Notice and Call Letter both propose changes affecting the Medicare Advantage (MA) and Part D programs payment and policies for CY 2019.

Today, nearly 40 percent of Medicare beneficiaries with Part A and B coverage are enrolled in a MA plan. In addition to the growth in MA enrollment, the majority of seniors have access to a large number of plans, and 90 percent of seniors report satisfaction with their plan according to the Medicare Payment Advisory Commission (MedPAC). These data points help underscore the inherent impact these proposed program changes could have on our seniors. Therefore, we encourage you to ensure changes adopted keep costs for beneficiaries low, preserve beneficiary choice, and ensure seniors' access to coordinated care remains strong.

Many of the proposals in the Administration's Advanced Notice and Call Letter will allow plans to offer high-quality, efficient, and patient-centered coverage options for beneficiaries – and we are pleased CMS addressed a number of previously identified issues in this notice. For instance, CMS is proposing a new definition of supplemental benefits, which will allow plans to expand the items and services they offer to Medicare beneficiaries. CMS is further improving the MA benefit by proposing to waive uniformity requirements, which will allow plans to reduce cost-sharing, offer tailored supplemental benefits, and offer lower deductibles for beneficiaries who

meet certain medical criteria. Other positive aspects of the proposal include the establishment of a technical panel that will work with stakeholders on future enhancements to the Star Rating System and the relief provided to plans serving beneficiaries in disaster areas. Finally, we are encouraged by CMS' continued commitment to the goal of finding a long-term solution to the unique challenges of serving our most vulnerable populations.

Despite these positive steps forward, there are a number of other policy areas that deserve CMS' attention to ensure that the quality and affordability of care for seniors is not eroded. To that end, we outline issues of concern below and request that CMS provide additional information on these issues to help us better understand CMS' proposed course of action.

Encounter Data: Since 2014, the Government Accountability Office and the Department of Health and Human Services Office of the Inspector General have reported problems with the accuracy and completeness of encounter data. Although CMS has made improvements to the Encounter Data System, significant progress to resolve these issues has yet to be made. Recent actions and statements by CMS show the agency is also aware of these challenges. While moving from the Risk Adjustment Payment System to the Encounter Data System will improve the MA program and reduce needless coding intensity reductions, before CMS moves forward with the proposed timeline for full-phase in of encounter data, CMS should use its existing workgroup and work with the plans to establish a timeline for full-phase in, along with minimum milestones that must be achieved. It is imperative that CMS do more to work with plans and to ensure the accuracy and completeness of data are resolved on their end before continuing with the proposed timeline. We believe the goal of robust, accurate, and timely encounter data would be best advanced by the creation of a technical panel bringing together industry experts and CMS program staff. Additionally, we request annual updates on the improvements made to the encounter data system, as well as an update on how CMS hopes to engage the plans in this process.

Employer Group Waiver Plans: For CY 2019, CMS is proposing to fully phase-in a new payment methodology, originally proposed by the Obama Administration. This payment methodology is not set based on actual bids submitted by the Employer Group Waiver Plans (EGWPs), but is instead based off bids submitted by non-EGWP plans. This new payment methodology may reduce employers' ability to provide retiree benefits through a consolidated health plan encompassing both Medicare benefits and supplemental retiree offerings, thus reducing beneficiary choice. Accordingly, we request that CMS reconsider the changes finalized by the previous Administration as part of the CY 2017 Final Notice and instead find a payment methodology that will best account for the difference in the proportion of beneficiaries who are enrolled in a Health Maintenance Organization (HMO) versus a Preferred Provider Organization (PPO). Additionally, we request CMS to analyze, and make public, the impact of this proposed change prior to a full-phase in to ensure the millions of beneficiaries who were receiving coverage through an EGWP are not losing access to their employer sponsored coverage, nor seeing their benefits reduced as a result of this policy. Specifically, we are interested in the number of beneficiaries currently enrolled in an EGWP compared to 2016 and the number of EGWP plan offerings at the contract level, compared to 2016.

Fee-for-Service (FFS) Normalization Factor: CMS has proposed to continue to calculate the normalization factor using the linear method for CY 2019. Congress has yet to receive information previously requested surrounding historical projected normalization, including:

- the actual FFS risk score trends (pre-2011);
- the challenges CMS faces in calculating the normalization factor;
- details on why the projected CY 2014 Part C normalization factor came in above actual FFS risk score values; and
- what significant factors impacted the projected CY 2018 normalization factor to change as compared to the estimate under the quadratic method.

We respectfully reiterate our request for this information and additionally request the actual FFS risk score value for CY 2017.

Last year, in a response to the Ways and Means Committee dated June 5, 2017, CMS stated that it "will continue to explore options for providing greater stability between payment years." We request information regarding what options have been explored since April 3, 2017, or options that CMS is currently exploring.

Additionally, we are concerned with the proposed CY 2019 normalization factor for the Program of All-Inclusive Care for the Elderly, or "PACE" program. CMS projects this factor will result in a 6.3 percent reduction in payments to PACE programs that serve a high cost, complex need population. We think it is important for CMS to find a better way to project risk scores so that payments to MA plans and PACE programs that provide high-value care to our nation's most vulnerable seniors are not being unfairly reduced. While efficiencies are important, this projected reduction warrants further context. Thus, we request that CMS provide us and PACE programs with a historical trend chart of the projected normalization factor and the actual risk score values from the past ten years.

Risk Adjustment: Over the years, changes to the risk adjustment model have made plans uneasy about what to expect year after year. For this reason, it is important that the model be as predictive, transparent and stable as possible. We urge CMS to work with the plans to create certainty and predictability in the modeling, as well as accurate accounting of diseases.

For the first time since 2012, CMS is proposing to update the End Stage Renal Disease (ESRD) risk adjustment model for CY 2019. CMS is required by law under Title XVII of the Social Security Act to properly risk adjust for the ESRD population in Medicare. While this is an important step in the right direction, it has taken seven years for CMS to decide to update this model. We ask that you provide the agency's rationale for waiting seven years to update this model and identify any challenges associated with more frequent updates to the risk adjustment model for the ESRD population.

The 21st Century Cures Act requires CMS to take into account the total number of conditions in the risk adjustment model. While CMS states that over twenty different models were considered, CMS only proposes and discusses two methods in the Advanced Notice and Call Letter: the "Payment Condition Count Model" and the "All Condition Count Model." We find that in order to ensure a smooth transition to a new risk adjustment model, plans need as much time as possible to adopt new changes. We request that CMS consider using its statutory authority to delay full implementation until 2020. Additionally, CMS should be transparent and work with the plans as they attempt to model these future changes. We request that CMS publish all twenty models that were considered in the Final Call Letter.

Benchmark Cap: Though we recognize the Administration's limited Secretarial authority to remove quality incentive payments from the benchmark, we urge the Secretary to review all options at his disposal to ensure high quality plans are not missing out on incentives to continue to improve care for our seniors. As CMS has recognized, the benchmark cap inherently undermines value-based care, which negates the incentive for MA plans to reach higher levels of quality and reduces or eliminates quality payments in many areas of the country. In certain counties, a 5-star plan could be paid the same as a 3-star plan. Our goal remains to encourage more plans to reach 4 or 5-star ratings.

Coding Intensity: Though CMS is required by law to set a minimum coding intensity adjustment, the Administration does have some flexibility in setting this amount each year as of 2019. We remain concerned over the impact these mandatory cuts will have on plan benefit offerings. We urge CMS to consider the impact this automatic reduction will have on plans going forward.

Puerto Rico: As you know, in Puerto Rico, nearly 75 percent of Medicare eligible beneficiaries are enrolled in a MA plan. It is clear that the Administration acknowledges the many challenges plans face in serving beneficiaries in Puerto Rico. While the adjustments in the Advanced Notice and Call Letter are needed, further consideration should be given to changes to the benchmark calculation in order to truly reflect the costs of the MA population in Puerto Rico.

Cost Plans: As required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), cost plans operating in certain areas will be required to transition to a MA plan as of CY 2019. Specifically, we are interested in learning more about CMS' strategy to ensure beneficiaries are properly educated and understand their healthcare options ahead of this transition.

In addition to the issues raised in the CY 2019 Advanced Notice and Call Letter, we would encourage the agency to consider additional policies to strengthen the MA program including:

Benchmark Calculation: Similar to our request last year, we request that CMS consider using its authority to calculate the MA benchmark based on per county FFS spending for beneficiaries enrolled in both Parts A *and* B. As you know, MA beneficiaries are required to enroll in both Part A *and* Part B coverage. However, due to the way the MA

benchmark is calculated, plans in certain areas are seeing lower benchmarks and ultimately lower payments. In the past, CMS has recognized the impact fewer Part B enrollees in an area has on the MA benchmark and has provided a similar adjustment for MA plans that serve beneficiaries in Puerto Rico.

Alternative Payment Models (APMs): We were very pleased with the mention of CMS' intention to develop a demonstration project to test the effects of expanding incentives for eligible clinicians to participate in innovative alternative payment arrangements under Medicare Advantage in the CY 2018 Quality Payment Program Final Rule. We urge CMS to move expeditiously to publicly explain its plans in the near term for creating a narrow adjustment for physicians participating in fully-capitated MA arrangements through the aforementioned demonstration. In addition, CMS states it will begin collecting APM information from plans in April 2018 and from clinicians in 2019. We encourage the agency to begin both processes on the same timeline, beginning in April 2018.

MA Plan Deeming: Under current law, MA plans may be deemed as satisfying Medicare requirements in the following areas: (1) quality assessment and improvement; (2) confidentiality and accuracy of medical or other enrollee health records; (3) anti-discrimination; (4) access to services; (5) information on advance directives; and, (6) provider participation rules. We encourage CMS to consider using its existing legal authority to apply the deeming program to MA plans that have been accredited by private organizations in areas such as appeals, grievances, and organization and coverage determinations. This is consistent with the broad authority Congress intended and provided under both categories (1) and (4). Further CMS should use its authority to expand deeming to the review of Special Needs Plans' compliance with the models of care they have filed with CMS.

We remain committed to working with you on common sense policies that promote choice, encourage plan innovation to improve care, and ensure continued access to Medicare benefits through the MA program. We respectfully request a response at your earliest convenience and appreciate your consideration of our concerns.

Sincerely,

PETER ROSKAM
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